

MEDICAL RELEASE FORM
(CONFIDENTIAL)

I, _____, have retained Medical Financial Consulting
(Patient name)
and/or its designated representative (Lori Harris, RN) for review of services and charges
incurred by the patient at your facility.

Lori Harris, RN has the authority to review and/or have access to any and all medical
Nursing Facility / Hospital bills, insurance claim forms, and all medical records including
treatment for communicable or infectious disease, drug or alcohol abuse, HIV or mental
health treatment.

Lori Harris, RN will interact with _____ for the
purpose
(Name of facility)
of acquiring the necessary information, documentation, or to clarify questions that may
arise during the review.

Facility Address: _____

City: _____ State: _____ Zip Code: _____
(I agree that a photographic copy of this authorization will be as valid as the original.)

Patient Signature

Date

Insurance Company Name

Nursing Facility / Hospital
Confinement Dates:

OR

Patient Authorized Representative:

Relationship

Explanation of why patient cannot sign:

The hospital requires that the patient must sign this authorization unless he/she is
deceased, a minor, judged mentally incompetent by a court of law or otherwise medically
unable to sign.

The authorized person means the parent, guardian or legal custodian of the minor patient,
the guardian or conservator of a patient judged incompetent, the spouse of a deceased
patient or a person designated in writing by the patient. In the case that a spouse does not
survive a deceased patient, a member of the deceased's immediate family may qualify.

Should you have any questions regarding this matter, please feel free to contact Lori
Harris, RN @ (269) 217-7829.

